Hunter Chiropractic Wellness Centre **Admittance Form**

Name:________________________ Gender: ☐ M ☐ F	Cell Phone:________________
Address: ______________________________	Home Phone:________________
City:______________Prov:______Postal Code__________	Work Phone:________________
Birth date: Month: _______ Day: _______ Year: _______ Age: ______	Spouse/Partner Name:____________
Email:______________________________	Spouse/Partner Phone:____________
Occupation:__________________________	Insurance company:______________
	Coverage amount: $ __________ per year

How did you hear about our office: ______________________________

Have you had previous chiropractic care? ☐ No ☐ Yes If yes, approx. how long ago:________________

Indicate your primary symptom: ______________________________

Is your symptom due to an accident? ☐ No ☐ Yes Type of Accident: ☐ Auto ☐ Work ☐ Other

When did your symptom begin?__________________ **Have you had this symptom before?** ☐ No ☐ Yes

What do you think caused your symptom?______________________________

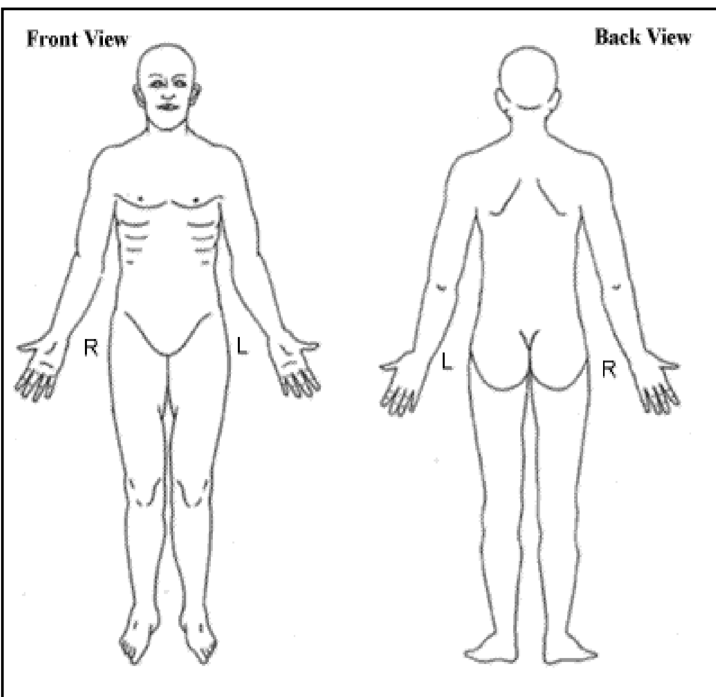
Have you had previous treatment for this symptom? ☐ No ☐ Yes If so, specify what and when:

____

Have you had X-rays, MRI, or other tests for this symptom? ☐ No ☐ Yes If so, specify what and when:

____

Does this symptom interfere with your: ☐ work ☐ sleep ☐ personal life ☐ mood ☐ activities ☐ other



Rate the intensity of your symptom (please circle):

(least) 1 2 3 4 5 6 7 8 9 10 (worst)

Is your symptom: ☐ **Constant; or** ☐ **Occasional**

What aggravates your symptom?

____

What relieves your symptom?

____

Indicate on the diagram (to the left):

S - for Sharp pain
D - for Dull pain / ache
T - for Tingling/ numbness
B - for Burning / throbbing

HEALTH HISTORY

Circle "C" for conditions you are currently experiencing or "P" for conditions you have had in the past.

Unexplained weight loss	**C | P**	Slurred speech	**C | P**	Poor concentration or memory	**C | P**	Headaches	**C | P**
Unrelenting pain (day and night)	**C | P**	Previous stroke	**C | P**	Frequent colds/infections	**C | P**	Jaw pain	**C | P**
Loss of bowel/bladder function	**C | P**	Blurry/double vision	**C | P**	Anxiety/depression	**C | P**	Neck pain	**C | P**
Fever/Chills/Sweats	**C | P**	Heart palpitations	**C | P**	Stomach pain	**C | P**	Mid-back pain	**C | P**
Poor appetite	**C | P**	Fainting or dizziness	**C | P**	Constipation/diarrhea	**C | P**	Shoulder pain	**C | P**
Pain over heart	**C | P**	Ringing in ears	**C | P**	Heartburn	**C | P**	Elbow pain	**C | P**
Spitting up blood/phlegm	**C | P**	High/Low blood pressure	**C | P**	Poor digestion	**C | P**	Wrist/hand pain	**C | P**
Difficulty swallowing	**C | P**	Difficulty sleeping	**C | P**	Varicose veins	**C | P**	Low back pain	**C | P**
Nausea/vomiting	**C | P**	Tremors	**C | P**	Cold/swollen hands or feet	**C | P**	Hip pain	**C | P**
Blood in stool/urine	**C | P**	Chronic cough	**C | P**	Ear infections	**C | P**	Ankle/Foot pain	**C | P**
Difficulty breathing	**C | P**	Painful urination	**C | P**	Painful/irregular cycles	**C | P**	Numbness/Tingling	**C | P**

Indicate any secondary conditions concerning you:____

____

Indicate all other health diagnoses given: ____

Check ✓all repetitive stressors you are currently experiencing:

Prolonged sitting	☐	Desk / computer work	☐	Repetitive lifting	☐	Emotional stress	☐
Prolonged standing	☐	Poor posture	☐	Repetitive sports/hobbies	☐	Lack of sleep	☐

Other repetitive stressors:____

____

List all medications and supplements you are currently taking:____

____

List all previous surgeries, illnesses, accidents and injuries:____

____

____

Other relevant health information:____

____

Females: Are you pregnant? ☐ No ☐ Yes ☐ Not Sure If yes: Due Date: ____________________________

Patient signature: ____ Date: ________________